

LSG INSURANCE APPLICATION FOR GAP COVER



PERSONAL PARTICULARS

APPLICANT (Must be the principal member of the medical aid)

First Names: **Surname:** **Date of Birth:**
Email Address: **ID No.:**
Physical Address: **POSTAL CODE:**
Postal Address: **POSTAL CODE:**
Tel (Business): **Tel (Home):** **Tel (Cell):**
Medical Aid Name: **Option:** **Member No.:**

MEDICAL QUESTIONNAIRE

- Do you or any of your dependants suffer from a chronic or recurring illness or serious ailment? YES NO
- Do you or any of your dependants expect to be hospitalised during the next 12 months? YES NO
- Are you or any of your dependants currently pregnant? YES NO
- Have you or your dependants suffered from any ailment/s or been hospitalised within the last 12 months? YES NO

If "Yes" to any of the above please specify the condition for which hospitalisation was necessary including medication which is taken regularly.

DEPENDANT	DATE HOSPITALISED	REASON FOR HOSPITALISATION / TREATMENT

Account Holder: **Branch Name:**
Account No.: **Branch Code:**
Name of Bank: **Account Type:** Current Transmission Savings

I hereby authorise the insurer or its representative, on acceptance of my application for cover to debit my account with the premiums payable under the above plan, on the first day of each month in accordance with the Debit Order System. Such authorisation shall remain in force and effect until cancelled by myself in writing, subject to two calendar months' notice. The narrative which will appear on your bank statement includes "EPIC/LSG".

<input type="text"/>	<input type="text"/>	<input type="text"/>
BANK ACCOUNT HOLDER AUTHORITY	DATE	ACTIVATION DATE

DECLARATIONS BY APPLICANT FOR MEMBERSHIP

I hereby declare that I have not withheld any information and I accept that this application and declaration shall be the basis of the contract of insurance between myself and Constantia Insurance Company Limited (CICL) which will become effective on the first day of the month for which premiums are paid. I confirm furthermore that I am currently a full-time member of staff*/self-employed*/retired* (*please delete 2 of these options) and irrevocably authorise the Administrators to collect from my employer/myself (as appropriate, per the debit order above) the monthly premium as quoted.

I hereby declare furthermore that the foregoing statements (and any other supplementary forms as requested by CICL), whether in my handwriting or not, are true and correct and shall be the basis of the contract and I agree that it is a condition precedent to the payment of any proceeds of claim that no fact, judged to be material solely in CICL's opinion, has been withheld, misstated or concealed by/ from me. I/we, the client, have requested and instructed the broker not to complete a financial needs analysis. I/we further understand and acknowledge that this instruction not to proceed with a full financial needs analysis could have the effect that all my financial needs may not be properly addressed. Lastly, I fully understand that a full 3 month waiting period is a condition of individual membership of my proposed application.

<input type="text"/>	<input type="text"/>	<input type="text"/>
SIGNATURE OF APPLICANT	INITIALS AND SURNAME IN BLOCK CAPITALS	DATE